

Case Number:	CM14-0038647		
Date Assigned:	07/30/2014	Date of Injury:	08/29/2012
Decision Date:	01/26/2015	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/02/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Colorado. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The worker is a 48-year-old female who developed neck and back pain following an event at work on August 29, 2012 while assisting a patient. As of March 11, 2014 the worker complained of 6/10 neck pain radiating to right shoulder and 7/10 low back pain. Examination findings include reduced cervical spine range of motion, tenderness to palpation of both shoulders anteriorly and laterally, positive bilateral shoulder impingement, decreased lumbar range of motion, positive right-sided straight leg raise at 65 degrees, muscle spasm of the lumbar spine on both left and right paraspinal musculature. Diagnoses at that point in time include cervical thoracic strain with possible cervical radiculopathy, bilateral shoulder impingement syndrome with possible rotator cuff tear is, rule out right lumbar radiculopathy, complaints of depression and anxiety, complained of abdominal pain medication. Recommendations included a continuation of Prilosec, continued in treatment for ongoing depression/anxiety symptoms, referral for pain management consultation for possible epidural injections, referral for upper extremity EMGs and nerve conduction studies to rule out radiculopathy, referral for MRI of the cervical, thoracic, and lumbar spine to rule out herniated nucleus pulposus, referral for bilateral shoulder MRI scan to rule out rotator cuff tear, referral for internal medicine consultation to address abdominal complaints.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

EMG to Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Elbow complaints Page(s): 33. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Clinical Policy Bulletin: Aetna Clinical Policy Bulletin - Nerve Conduction Velocity Studies Number: 0502
http://www.aetna.com/cpb/medical/data/500_599/0502.html

Decision rationale: According to the Aetna Clinical Policy bulletin, nerve conduction velocity (NCV) studies medically necessary when both of the following criteria are met: 1. Member has any of the following indications: a. Diagnosis and prognosis of traumatic nerve lesions (e.g., spinal cord injury, trauma to nerves); orb. Diagnosis and monitoring of neuromuscular junction disorders (e.g., myasthenia gravis, myasthenic syndrome) using repetitive nerve stimulation; orc. Diagnosis of muscle disorders (e.g., myositis, myopathy); ord. Diagnosis or confirmation of suspected generalized neuropathies (e.g., uremic, metabolic or immune); ore. Differential diagnosis of symptom-based complaints (e.g., pain in limb or joint, weakness, fatigue, cramps, twitching (fasciculations), disturbance in skin sensation or paresthesias [numbness or tingling]) provided the clinical assessment supports the need for a study; orf. Localization of focal neuropathies or compressive lesions (e.g., carpal tunnel syndrome [see selection criteria below], tarsal tunnel syndrome, nerve root compression, neuritis, motor neuropathy, mononeuropathy, radiculopathy, plexopathy); and 2. The member has had a needle electromyographic (EMG) study to evaluate the condition either concurrently or within the past year. The requirement for needle EMG with NCV may be waived for persons on anti-coagulant therapy with warfarin (Coumadin), direct thrombin inhibitors (e.g., dabigatran (Pradaxa), desirudin (Iprivask)), or heparins that cannot be interrupted. It may also be waived when the purpose of the NCV study is solely to diagnose or rule out one of the following: carpal tunnel syndrome, myasthenia gravis or Lambert-Eaton myasthenic syndrome. In this case, there is insufficient documentation of any of the criteria provided by the Aetna Clinical Policy Bulletin. Specifically, there is insufficient documentation of specific neurologic complaints such as numbness or tingling or other potential focal neuropathy. Therefore the request for bilateral upper extremity nerve conduction studies or needle electromyographic studies (EMG), is not considered medically necessary or appropriate.

Magnetic Resonance Imaging of the Cervical Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back, Imaging

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cervical and upper back Page(s): 177.

Decision rationale: According to the MTUS, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. The criteria for ordering imaging studies include

the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and, clarification of the anatomy prior to an invasive procedure. In this case, the request for cervical spine MRI scan appears necessary and appropriate because of failure to progress or improve following an extended period of time that exceeds a 4-week period of conservative care and observation.

Magnetic Resonance Imaging of the Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): page 303. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Imaging

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cervical and upper back Page(s): 177. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Clinical Policy Bulletin: Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) of the Spine. Number: 0236 <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html>

Decision rationale: According to the MTUS, for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. The criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and, clarification of the anatomy prior to an invasive procedure. These criteria are not specific to the entire thoracic spine. There are no MTUS criteria addressing the thoracic spine in its entirety. According to the Aetna Clinical Policy Bulletin, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) of the Spine. Number: 0236, a magnetic resonance imaging (MRI) of the spine (i.e. all levels including the thoracic spine) may be medically necessary when any of the following criteria are met: - Clinical evidence of spinal stenosis; or- Clinical suspicion of a spinal cord or cauda equina compression syndrome; or- Congenital anomalies or deformities of the spine; or- Evaluation of recurrent symptoms after spinal surgery; or- Evaluation prior to epidural injection to rule out tumor or infection and to delineate the optimal anatomical location for performing the injection; or- Follow-up of evaluation for spinal malignancy or spinal infection; or- Known or suspected myelopathy (e.g., multiple sclerosis) for initial diagnosis when MRI of the brain is negative or symptoms mimic those of other spinal or brainstem lesions; or- Known or suspected primary spinal cord tumors (malignant or non-malignant); or- Persistent back or neck pain with radiculopathy as evidenced by pain plus objective findings of motor or reflex changes in the specific nerve root distribution, and no improvement after 6 weeks of conservative therapy; or- Primary spinal bone tumors or suspected vertebral, paraspinal, or intraspinal metastases; or- Progressively severe symptoms despite conservative management; or- Rapidly progressing neurological deficit, or major motor weakness; or- Severe back pain (e.g., requiring hospitalization); or- Spondylolisthesis and degenerative disease of the spine that has not responded to 4 weeks of conservative therapy; or - Suspected infectious process (e.g., osteomyelitis epidural abscess of the spine or soft tissue); or- Suspected spinal cord injury secondary to trauma; or- Suspected spinal fracture and/or dislocation secondary to trauma (if

plain films are not conclusive); or- Suspected transverse myelitis. In this case, there is insufficient documentation of symptoms localized to the thoracic spine and therefore, the request for thoracic MRI scan is not considered medically necessary or appropriate.

Magnetic Resonance Imaging of the Lumbar Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Imaging

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Complaints Page(s): 303-304.

Decision rationale: According to the MTUS the medical necessity criteria for MRI scan of the lumbar spine include the following: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination; When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction (e.g. Electromyography (EMG), including H-reflex tests) lasting more than three or four weeks should be obtained before ordering an imaging study; An imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for one month or more to further evaluate the possibility of potentially serious pathology, such as a tumor. In this case, the request for lumbar spine MRI scan appears necessary and appropriate because of consistent symptoms that have persisted for one month or more.

Pain Management consultation: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Discussion Page(s): 4.

Decision rationale: Page 4 of the chronic pain medical treatment guidelines provide rationale for a pain specialist consultation via its qualification of chronic pain. The MTUS states that there is a clinical decision to recognize the chronicity or persistence of pain when 1. The condition is not improving over time, 2. Fails to improve with treatment directed to the specific injured body part, or 3. In the absence of a specifically correctable anatomic lesion. Also, as provided by ACOEM, chronic pain may be best characterized as "chronic pain persists beyond the usual course of healing of an acute disease or beyond a reasonable time for an injury to heal." The medical records reflect that the worker's symptoms do include complaints of pain which may or may not, correlate to examination findings that are persistent despite treatment. Although the request for authorization is for a pain management consultation there is an inference that the request for this consultation is in the context of obtaining an epidural steroid injection. The referral however appears to not be for epidural steroid injection but rather for pain management consultation. And therefore, the request for pain management consultation does meet medical necessity criteria and is therefore considered medically necessary and appropriate.

Internal Medicine Consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 6.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Gastrointestinal disorders. Bibliographic Source(s) American Medical Directors Association (AMDA). Gastrointestinal disorders. Columbia (MD): American Medical Directors Association (AMDA); 2006. 28 p. [24 references]
<http://www.guideline.gov/content.aspx?id=9380&search=internal+medicine+referral+and+abdominal+pain>.

Decision rationale: According the referenced guideline, gastrointestinal disorders most commonly seen in the long-term care population, which may require internal medicine referral, may include abdominal pain, gastroesophageal reflux disease (GERD), constipation, diarrhea, and gastrointestinal bleeding. In this case, there is insufficient documentation of the clinical characteristics of the worker's abdominal complaints. Specifically, there is no reference to pain, diarrhea, constipation, reflux, or bleeding. Therefore, the request for internal medicine consultation is not considered medically necessary or appropriate.